DOCUMENT RESUME

ED 157 311 EC 111 796

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TITLE Progress and Problems in the Delivery Service System to Hard of Hearing Children from Identification, Remediation and Prevention.
PUB DATE Jun 78
NOTE 11p.; Paper presented at the World Congress on Future Special Education (First, Stirling, Scotland, June 25 - July 1, 1978)

EDRS PRICE MF-$0.83 HC-$1.67 Plus Postage.
DESCRIPTORS Aurally Handicapped; *Delivery Systems; Elementary Secondary Education; *Foreign Countries; *Hard of Hearing
IDENTIFIERS *Great Britain

ABSTRACT

The paper provides an overview of Great Britain's delivery system for services to the hard of hearing child. Sections focus on identification, assessment, schooling, placement factors, integration, prevention, support services, and future trends. (SBH)

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JUL 3 1 1978

World Congress on Future Special Education - June, 1978 - Stirlin

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Progress and Problems in the Delivery Service System to Hard of Hearing Children from Identification, Remediation and Prevention

Learning, if not schooling, begins with the first breath of life and continues until the last breath.

The areas to consider are Discovery, Medical Intervention, if possible, Family Guidance, Schooling. I don't propose to discuss medical or surgical intervention as I am not competent so to do, but, of course, I do not underrate the importance of this aspect of rehabilitation or prevention.

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Discovery

It is not a simple matter to discuss this in the context of an international congress as the conditions from country to country differ widely. There could be an organisation whereby a systematic search can be conducted to look for and discover babies or older children who may have hearing losses or, on the other hand, no organised system and it is left to chance whether a family doctor or a parent or indeed a grandparent or friend is observant enough to doubt the ability of a child to hear normally. In a country such as Great Britain it is possible to establish an organised system. There is a National Health Service within the framework of which such an organised system is possible and does exist with varying success from place to place. The country is divided into Area Health Authorities in which there are sub-divisions known as districts. Each area, and hence each district, has a responsibility to look for and identify, among various childhood problems, the baby or older child who may have any significant degree of deafness. The mechanics of this varies. In some areas this is conducted at a baby clinic and the investigation carried out by a doctor and an assistant.

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In other areas this is carried out by a health visitor in the home. A health visitor is basically a nurse with additional qualifications among which would be the ability to look for abnormal conditions such as abnormal hearing. I wish to stress here that this process is screening, that is, not diagnosis of deafness but to answer one simple question which is "Does this baby respond normally to sound". The sounds presented are very quiet sounds and cover low and high frequencies separately. If the baby does not appear to respond normally there should be a referral to an audiology centre in which there is a team of professionals expert and experienced in the field of hearing, deafness and communication generally. If there is no organisation in which systematic searching can be carried out then it is left to chance. There are parents who are particularly observant and spot a hearing problem very early in life, but this is unusual if left to chance. The period in which one gets the best chance of valid screening of hearing seems to be at a developmental age of 7 - 9 months. At this stage the baby is able to turn his head from side to side and will do so if quiet sounds are presented laterally and out of sight, and if he has normal hearing. It is most important to try to discover babies with abnormal hearing within the first year if at all possible as only by so doing will it be possible to achieve optimal development of language and communication. That is to say that although good results may be obtained if the hearing impaired child is discovered later than this, nevertheless, I do not believe they could be as good as if this child had been found, and treated, earlier.

With otherwise normally developing babies there is no great problem in determining the level of hearing in broad terms. Those with good hearing for low tones but losses at higher frequencies often present problems and may be missed but with careful procedures by experienced workers this becomes less likely. When there are complicated factors such as a cerebral

palsied condition, visual or other central nervous disorders it is not so easy to determine the exact state of hearing and resort has to be made to so-called objective tests of hearing.

The next stage at which an organised system can be established, and this can be carried out in all countries if the personnel is available, is on school entrance whether this is nursery education or at a later stage. The persons conducting this screening procedure may be nurses, teachers or any suitable person provided they are trained for the work. This is usually carried out using a pure tone audiometer and presenting different frequencies at a pre-determined level such as 15 or 20 db (SPL). Once again it is only a screening procedure and any child not responding normally should be referred to an audiology centre.

Assessment

Having discovered a baby or child has abnormal hearing the first essential diagnosis must be whether medical or surgical treatment can cure or alleviate the condition. If not then the treatment is essentially social, psychological and educational.

The assessment of the child must in my opinion be comprehensive and conducted by a multi-professional team. In this country there is controversy as to the nature of the audiologist. In my opinion the paedo-audiologist should be a person from any of the involved disciplines, i.e. medicine, education, psychology, social work, speech therapy, provided that person has had extra training and knows about the management of young children and hearing and deafness. That is, the essential personnel in the team must be, paedoaudiologist, otologist, psychologist, teacher of the deaf, speech therapist, social worker and audiology technician. Only when all is known of the nature of the child's condition and his environment, can adequate and valid guidance be given. I have called this family guidance and not parent guidance as brothers and sisters may have a large part to play in the

total development of a hearing impaired child although in most cases the mother would play the largest part. The parents may need much support during this time and although a teacher of the deaf, as a member of the team, may play the leading on-going role, sometimes the social worker, sometimes the psychologist, and sometimes, but less frequently, the doctor, may have varying parts to play.

In babyhood it is not easy precisely to know what characteristic to use in a hearing aid, or whether two hearing aids should be issued. However, with careful handling of the hearing aid and the guidance offered to the family, much good can ensue.

Schooling

After some time of guidance decisions have to be taken about schooling. Much depends upon the progress of the child linguistically and the relationship between the mother and child. If the child is progressing well enough and the relationship good enough, it may be more beneficial for the child to remain outside the framework of formal schooling and remain in the home. In some cases a decision is made on social or educational grounds that the child should be in a larger or more expert community. The difference in such decisions depend so often on what is available in a community and also on the policy of the local education authority and the wishes of the parents. Certainly, there should be the availability of all kinds of educational environments, as near as possible to the home, for all the needs of hearing impaired children. By this I mean those suitable for deaf children, for partially hearing children, and for those who can manage in a normal setting with or without special support.

I must at this stage offer some definitions as I am supposed to be talking about hard of hearing children, a phrase we do not use in the UK, but which, I hope, refers to those we call partially hearing children. If we must use labels then I will do so but I will not use an audiometric definition. We know that there is a continuum from total deafness to

slight degrees of loss of hearing. However, besides hearing loss there are twenty or so other factors which affect the development of language and communication in a hearing impaired child. Therefore, I suggest the only way to handle such a problem is to ensure that there is an educational environment and support system in which all children can be placed according to their educational, social and emotional needs. For learning we need an adequate communication system. Therefore, if we have discovered the hearing impaired child early enough and offered the right kind of help and guidance we can then decide, when the child is at an age for going to school, on his actual development in speech reception, the kind of environment in which to place him. At what rate does he receive oral communication? If through hearing and/or lip reading he can receive at a reasonably normal rate then the normal class is the right place perhaps with a measure of support. If it is somewhat less than this, then special arrangements for partially hearing children may be necessary and if this ability is very seriously impaired then he is educated as a deaf child.

Children already in school who are discovered to have a loss of hearing will, presumably, be those with partial or variable loss of hearing. After surgical or medical intervention has been considered a decision must be made on educational and psychological grounds. It must be remembered that what might conceivably be thought to be an insignificant loss of hearing in clinical situations, may, in a classroom situation, be quite significant enough for the child to misshear and then lose concentration and attention, and therefore should be considered when offering advice. Such children may need support even if it is only advice to his teacher.

Variable Factors

I have said that hearing level alone should not determine placement. Some children may respond well enough, even with extremely severe losses of hearing, to be placed satisfactorily in a normal situation and yet some with much more

hearing may require the greater support available in a special school situation. Such factors which influence the position are:

I Hearing Impairment

1. Degree of deafness
2. Cause of deafness
3. Age of onset
4. Age of ascertainment
5. Variability of deafness

II Use of Hearing Aids

1. Continuity of use
2. Efficiency of the aid

III Other handicaps

IV Intelligence

V Linguistic Aptitude

VI Personality

VII Socioeconomic status and attitude.

VIII Deafness in the family

IX Parental Attitude

X Relationships with siblings

XI Size of family

XII Guidance to the family

XIII Medium of communication

XIV Type and size of school

XV Continuity and quality of education

XVI Attitude of school

To assess and try to evaluate the sum of all these factors of necessity involves several disciplines and therefore the need not only for the assessment of each factor but also the close consultation between all these professionals and also the parents.

Integration

It has been my philosophy for many years that all handicapped children need some measure of integration in their educational years, the amount of which would vary depending upon the child's need for (1) education (2) social development, provided the stresses are not too great for him to remain normally emotionally stable. The amount of integration therefore could be nil or total through any degree between these two limits.

In London there are segregated schools for deaf children, units for partially hearing children and many children with hearing aids with support from peripatetic teachers in classes for normally hearing children. There is a large overlap of hearing disability in all cases. The fact that there are special schools for the deaf is, of course, historical and when a school has to be re-built perhaps thought will be given to some new ideas such as being semi-detached with a school for hearing children. Most of these schools do, in fact, make some arrangement for the children to meet and mix with hearing children in some way or other.

Generally the emphasis in our work with partially hearing children in London is to make the maximum use of whatever hearing the child has, to have them in units within the normal school situation and to integrate whenever possible provided it is of general benefit to the child bearing in mind the three aspects of educational and social needs within the framework of emotional stability.

The first primary unit for partially hearing children opened in 1947 and now with a school population of about 400,000, there are about 350 partially hearing children in 9 primary and 6 secondary partially hearing units. There has been a shift in the population during the years so that the children in these units are now deafer than in 1947 due to earlier discovery, more effective parent guidance, better hearing aids and more peripatetic teachers of the deaf.

Prevention

The first aspects of prevention must, of course, depend upon the present medical knowledge available. Having said that, there are educational, social and psychological problems which, with care and good organisation, should never occur. So many of these problems have arisen because hearing impairment has not been discovered early enough or, what is worse, having been discovered, no action taken or not thought to require special help. The moment any hearing impairment is discovered total assessment of the child, his environment and his achievements should take place, then, after due consultation and consideration action of one kind or another be organised.

Support Services

Throughout the child's school career there must be adequate supervision. In special schools this obviously happens if the staff are suitably trained. In the unit situation there must be a suitable number of teachers of the deaf to provide for the special needs of the hearing impaired children and guidance to the teachers in the main school. For those hearing impaired children in normal schools (or main stream) there must be teachers of the deaf to visit as frequently as necessary to support such children and advise the teachers in the school.

Consideration must be given to the acoustic conditions not only in special schools and classrooms but in all classrooms into which hearing impaired children may go if they are to receive optimal benefit. In their own special classrooms fixed amplifying equipment may be installed but where the child moves from room to room it is probably better to use radio aids on all occasions.

The future

The most recent education act has a most controversial clause - clause 10. This requires local education authorities to arrange for the special education of all handicapped pupils to be given in county and voluntary schools (normal), except where this is impracticable, incompatable with the efficient instruction in the schools or involves unreasonable public expenditure, in which case it could be given in special schools. Although I believe in a measure of integration

I believe there are too many dangers for hearing impaired children if this were to be carried too far. It could conceivably benefit the present group of hearing impaired children if with a wave of a magic wand it could happen at once in so far as we have a large number of experienced and trained teachers of the deaf. However, not all are equally capable. So some children would do well and others not so well. In a school (or unit) the weaker teachers can be helped by the stronger teachers.

There are still not enough trained teachers of the deaf and certainly not enough to go round at the moment. In a generation or two the older teachers would retire and new teachers of the deaf, working singly, could not benefit from the experience of older colleagues and in time the corpus of knowledge would slowly be lost and could never be restored from books. A certain amount of loss would stem from teachers seeking promotion which could only stem from leaving the world of hearing impaired children and so continuity would be shortened.

However, the future must have a greater measure of integration but not at the expense of expertise. If we are to educate our children completely we must put them into situations in which they are able to learn the trials and tribulations of living with their deafness in a hearing world. This, in my opinion, can best be carried out by living in such a milieu during most of their formative years with supportive help from teachers of the deaf. My conclusion after many years of observation is that this is best achieved by having special schools built as part of normal schools with a complete hierarchy of staff in each and integration not only of children but of the staff as well. However, there will be areas where this can only be organised as units within normal schools due to small numbers. The degree of integration will vary from child to child and also from time to time.

If we are to provide hearing impaired children with optimal achievement in education and also in their ability to lead successful adult lives in a hearing world there must be mandatory regional development of services, dependant upon child population to provide:

1. A systematic discovery service

2. An audiological service comprising:

   (a) An adequate building

   (b) An adequate team of:

      Paedo-audiologist

      ENT surgeon

      Psychologist

      Social Worker

      Speech Therapist

      Teacher of the Deaf

      Technician

   and the availability of:

      Psychiatrist

      Paediatrician

3. A complete educational system to provide for:

   (a) Parent guidance

   (b) Profoundly deaf

   (c) Partially hearing

   (d) Deaf children with additional handicaps

   (e) Partially hearing children with additional handicaps.

4. Continued re-assessment of the child and his environment.

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